DEPARTMENT of CHILDREN and FAMILIES
Making a Difference for Children, Families and Communities

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Urgent Crisis Center / Sub-Acute Stabilization Center
RFP #230718001
Questions & Answers

1. Is there a specific reason why the RFP for Urgent Crisis Centers and Sub-Acute Stabilization does not include funding for Region 2 (referenced on Page 4)? Hartford, Region 1, 3 & 5 are listed as eligible locations.
   Answer: There was an amendment to the RFP which stated the following that there are 4 areas of the state where UCCs and SAs are to be procured:

   North Central: Inclusive of Hartford, Manchester, New Britain, Meriden and Enfield
   Eastern: Inclusive of New London, Old Saybrook, Willimantic and Norwich
   Southern: Inclusive of New Haven, Milford, Bridgeport and Stamford
   Western: Inclusive of Waterbury, Danbury and Torrington

2. Do you know the reason why New Haven was left out of the urgent care center RFP?
   Answer: See the response to question 1 above.

3. Does the Sub Acute have to be ligature free?
   Answer: Both UCC and Sub Acute will have to be ligature resistant: "Without points where a cord, rope, bed sheet, or other fabric/material can be looped or tied to create a sustainable point of attachment that may result in self-harm or loss of life"

4. What do you mean by hospital level standards?
   Answer: Both UCC and Sub Acute will have to be ligature resistant: "Without points where a cord, rope, bed sheet, or other fabric/material can be looped or tied to create a sustainable point of attachment that may result in self-harm or loss of life"

5. What licenses will be needed for the UCC and Sub Acute Stabilization?
   Answer: UCC will be licensed by either DPH or DCF as an Outpatient Clinic and Sub Acute Stabilization will be licensed as a Child Caring Facility. If the site is part of a hospital, it will fall under a DPH license.

6. Is a child care license required for both levels?
   Answer: No, see question 5.

7. You reference sub-contracting in the RFP? Does this apply to affiliations? Does it apply if more than one organization wants to collaborate?
   Answer: Agencies can apply to directly to serve as either an UCC, a sub-acute, or both. If two agencies propose an agreement to apply collaboratively, this would not be considered subcontracting for one or the other service.

8. Is it correct that there is no funding for capital improvement?
   Answer: There is funding available for build out of an ambulance bay at the UCC, separate from the funding delineated in the RFP. Applicants are free to propose capital improvement costs in the proposal budget, within the allocations defined in the RFP.

9. Do you expect the applicants to have site control upon application?
   Answer: No

10. Is there consideration having a rolling application so that providers have opportunity to put together proposal that meet the requirements?
Answer: No, however, this may be considered based on the responses received to the RFP.

11. What do you envision the mobile crisis/EMPS relationship to be?
Answer: There does need to be coordination with Mobile Crisis agencies, and it is anticipated that Mobile Crisis will be a referral source and part of a comprehensive discharge plan. Your proposal should detail how your relationships will facilitate these collaborations.

12. If there are funds available from salary savings during startup, can they be used toward facility renovations?
Answer: Yes

13. What are thoughts about sustainability, ARPA dollars will run out, what assurances will be offered for future funding?
Answer: While no assurances can be made, the Department has begun conversations with OPM regarding this service's place in the DCF service continuum.

14. When referring to reimbursement on the UCC side, is that going to be emergency urgent care reimbursement?
Answer: At this time, we don't know. DCF is actively working with DSS to design the reimbursement structure for this service and will include awarded providers as a result of this RFP in those future conversations.

15. UCC outlines applicants should partner with EMPS and police, has there been an agreement to divert 911 ambulance to a UCC?
Answer: Yes. These changes were legislatively implemented in the 2022 state session.

16. Can the UCC be adjacent to a current Emergency Department with a shared triage?
Answer: Yes

17. What things would require a patient to be transferred from UCC to a medical department?
Answer: In the RFP, page 11 (section e) describes circumstances which would require a child to be transferred to the emergency department.

18. Payment for UCC, would it require a new SPA waiver, or is there a plan to utilize current plans of the state?
Answer: Refer to question 14.

19. The sites should be Ligature-free? Is this broadly speaking? Or is ligature resistant? Clarify?
Answer: Refer to question 4.

20. Potential applicants, not limited to nonprofits urge the department to rethink use of sub-contracting, need to have relationship with ED. Urge to think broadly and creative way for people to become eligible for state dollars. Could suggest in the proposal? At least for the UCC, there are going to be kids that come in that will need to be hospitalized. Reconsider ban on sub-contracting.
Answer: See question 46.

21. In the RFP, there are four areas mentioned, with two different levels of care. There are 1 to 8 Awards. What does this mean?
Answer: There are 4 awards available for the Urgent Crisis Centers and there are 4 awards available for the Sub-Acute Stabilization. Agencies can apply for either the UCC, Sub Acute, or both. If an agency is awarded both, it is one contract/award.

22. Request is focused on expanding the continuum of care, it's unclear on how to get to lower level of care, please clarify when there is a need for a higher level care?
Answer: Pages 12 (sections g) of the RFP describes the process for discharge referrals and follow up. On page 11 (section e) describes circumstances which would require a child to be transferred to the emergency department or higher level of care.

23. How do you show connections with higher levels of care?
Answer: Describe any affiliation agreements, or letters of support indicating collaboration.

24. How do you expect to have a voluntary status when both the minor and the parent must consent? Would that no longer be the case?
Answer: Evaluation in the UCC and treatment in the Sub Acute require the consent of the guardian and the assent of the youth to such care. As per the RFP on page 11, if a child required to be held involuntarily to maintain their safety, this would require a transfer of the child to the Emergency Department. The facility needs to have the capacity to issue an emergency certificate for this purpose.

25. Can bonding money allocated for different purpose be used if we ask permission?
Answer: Permission would have to be granted by the Bond Commission, or authorizing agent of the bond funding for this reallocation.

26. If the agency finances the cost of capital expenditures, can we charge interests costs only (not the capitol costs) towards occupancy costs over the years of the contract.
Answer: Yes, for interest costs only.

27. Will you release the names of those agencies/people in attendance to the Bidders' Conference?
Answer: No

28. Similarly, will you post the names of those agencies that submit a letter of intent and which option(s) are being applied for?
Answer: Yes

29. What is the standard for medical screening? Is this a process that must be completed by a nurse and/or physician? Can screening forms be used by a non-clinician?
Answer: Physical examination must be completed by a licensed physician or APRN. The screening forms can be filled out by a non-clinician based on the physical exam and or clinical assessment by a clinician. Please refer to pages 11, 14, and 15 in the RFP.

30. Can you describe the billing structure associated with each program? Which codes/level of care designations are being used? It seems clear that there is an expectation of billing Medicaid for the SACS but more detail about this would be helpful. Can you describe the billing that would be done for the UCC?
Answer: See question 14.

31. The creation of the RFP aims to ameliorate the ED crisis – but it seems illogical to expect that direct admissions will be possible when this has been attempted unsuccessfully before. Can you describe the guidance that you will give to the inpatient units to encourage their participation in this systems change?
Answer: The Department is not able to dictate practice parameters to an inpatient unit. However, it is expected that the contractor for UCC or SA will demonstrate admitting privileges and/or referrals based on existing relationships and how these relationships will assist in obtaining appropriate care for youth when necessary.

32. If you apply in more than one region to do just one element (option A or option B), will DCF release the names of those other applicants (or those that submit an LOI) so that development of coordination of care can occur?
Answer: No, although the names of all parties submitting a Letter of Intent will be posted.

33. The timeline associated with start of contract appears tight, with decisions being made by October 1 and implementation starting November 1, but you are citing that you want all zoning and licensure compliance provided for property by October.
Answer: If the timeline for implementation is not attainable by the applicant, proposals may propose alternative implementation timeframes, but scoring preference will be given to applicants with the closest realistic implementation date to November 1st. Contracts will not be awarded until siting and zoning is secured.

34. Is there a size limit associated with the RFP response – in past RFPs for various CT agencies, applications have needed to be split into manageable chunks for complete transmittal. Is there guidance around this?
Answer: Please refer to page 21 of the RFP for details regarding proposal submissions.

35. Will the Department consider moving the deadline 45 days out to allow prospective bidders time to identify and potentially secure capital to invest in a site?
Answer: No

36. Will the Department consider moving the deadline 45 days out to allow prospective bidders more time to identify and secure a location that can meet all the requirements for this work?
Answer: No

37. Would the Department consider working with the 6 Mobile Crisis Intervention Services providers to implement the Urgent Crisis Centers as part of a continuum of response for youth and families rather than procuring a separate service? If these two services are provided by the same provider there will be much better continuity and a tighter response.
Answer: Mobile crisis agencies can apply to provide these services, however, eligibility to provide UCC or SAC services is not limited to these providers.

38. Is the Department interested in alternate levels of care to serve areas that are more geographically dispersed?
Answer: See question 1 for the requested catchment areas to be served by each UCC and SAC.

39. Does the Department envision the UCCs being located anywhere other than the grounds of a hospital?
Answer: Hospitals are eligible to apply implement UCCs, however, implementation of UCCs is not limited to hospitals as potential providers.

40. Please provide a detailed explanation of the building requirements for the UCCs, including licensing requirements for a ligature free environment.
Answer: Site requirements for UCC's are listed on page 10 of the RFP and must be ligature resistant (see question 4) and meet licensure regulations as an outpatient clinic.

41. Will the Department consider proposals that use existing programs with smaller capacity other than what is being specified in the RFP? An existing Therapeutic Group Home could be enhanced to serve as a step down and part of the crisis continuum.
Answer: Proposals should be responsive to the program parameters as identified in the RFP.

42. Will the Department consider other programmatic designs to meet the needs of youth in crisis?
Answer: Proposals should be responsive to the program parameters as identified in the RFP.

43. Has any work been done with Emergency Medical Services to allow for transport to an Urgent Care Center in lieu of a Hospital Emergency Department as currently their standard operating procedures only allow ambulance transport to a hospital?
Answer: See question 15.

44. If Emergency Medical Services refuse to transport to an Urgent Care Center how will this impact the volume of referrals?
Answer: See question 15.

45. It appears that you are allowing for-profit or out of state entities to apply for this grant which seems to be a deviation from prior practice. Can you please explain the justification for this change in eligibility?
Answer: Connecticut state agencies are statutorily prohibited from contracting for human services with anyone other than a private provider organization or unit of government. Proposals will be accepted from entities who may not yet have private provider organization status but are in the process of securing such. No contract will be awarded to any entity that is not a private provider organization or unit of government.

46. For projects of this size, it would seem that a partnership between two agencies (ie. a hospital and non-profit agency; or a psychiatric practice and a non-profit agency) might produce strong results. Would the Department please clarify why subcontracts are not allowed AND would they consider revisiting this decision?
Answer: Partnership among agencies is required of providers of this service. Sub-contracting is prohibited. Sub-contracting is defined as the awarded UCC/Sub-Acute provider contracting with another agency to perform the services required in DCF's contract with the awarded UCC/Sub-Acute provider. Partnership is defined as the awarded UCC/Sub-Acute provider formalizing a non-financial relationship that defines how the client will receive services.

Example: The UCC provider in Hartford will be expected to maintain relationships with Hartford Hospital and St. Francis Hospital to facilitate the transfer of Emergency Department clients to the UCC. The Hospital will not pay the UCC for this transfer and the UCC will not pay the Hospital. This is a partnership.

Example: The UCC provider in Hartford does not hire its own nursing staff but contracts with and pays St. Francis Hospital to staff the UCC with nurses. This is sub-contracting.

47. It is clear that we need to demonstrate a partnership between the levels of care if we choose to apply for only one option….It would be helpful to know who the other applicants were in our region in order to do some strategizing about our workflow & partnership. Please reconsider sharing either those that submit an LOI or the list of participants in the bidders' conference.
Answer: As per page 3 of the RFP, awardees of option A or B will be required to partner with the awardee of the corresponding program in the catchment area. Specific details of the partnership do not need to be provided as part of the proposal.

48. Can you clarify the amount of money available for creating an ambulance entrance & the process for this?
Answer: No. DCF will work with the awarded providers to negotiate a reasonable cost for the buildout of an ambulance entrance. There is not a 'set' cost.

49. Can Ted please clarify the licensing decisions for Option A and Option B?
Answer: See question 5.

50. You cite that it is the responsibility of the UCC to provide transportation to the subacute program if so needed. Are there regulations/guidelines that govern providing transportation for this level of care/need? Can this include the parent/guardian providing transportation?
Answer: See question 52.

51. The RFP notes that locations and licensure are required by October 15th. What if licensure cannot schedule a site visit by this date?
Answer: Expectation is as stated in RFP.

52. The UCC is required to provide transportation to the SACS Site. Does this have to be medical transportation? Will the grant cover a van for transportation?
Answer: DCF is not requiring medical transportation, although such should be able to be arranged if necessary. Applicants are free to include the cost of vehicle purchase in the proposal budget, within identified funding allocations.

53. The RFP notes that there are separate funds to cover renovations for an ambulance entrance for the UCC. How soon would the location need to be ambulance ready? Would other funding be readily available to apply to for this work?
Answer: DCF would expect providers to begin working on installation of an ambulance entrance as soon as practicable after contract award. Funding is available to begin the project immediately.

54. Staffing requirements for the UCC include 2 FTE Housekeeping staff. Can housekeeping be subcontracted out? Or is the expectation that they will be on site full time.
Answer: The RFP details 2 FTE's for housekeeping and it is anticipated these positions will be agency employees.

55. For the UCC do we need to provide meals or have a kitchen for meal prep?
Answer: Outpatient Clinic Regulations do not require the site to have a kitchen, however, they do set requirements for the kitchen, equipment, and food handling if location does have a kitchen.

56. Are formalized agreements with law enforcement and emergency medical services needed with every town in the region being covered or only the town in which the UCC is located? Also, do these agreements need to be submitted with the proposal?
Answer: Yes, proposals must demonstrate how you will partner with EMS and law enforcement and have formalized agreements. Agreements with law enforcement and EMS for transporting youth to your facility will need to be sufficient to ensure response to youth throughout your entire catchment area. Agreements regarding transporting youth from your facility to the Emergency Department would rely upon agreements with the responding emergency services to your site. The proposal should include a narrative describing the relationships.

57. Budget - it's noted that we need to include financial support for billable services and how it will offset cost of the center. Is it required to show revenue from Medicaid and commercial insurance as part of showing a balanced budget or more as informational?
Answer: At this time, this information (if available) would be informational. DCF recognizes that the components eligible for reimbursement under this model are still in discussion at the state level.

58. It is not noted in the RFP, for the UCC and the SACS program should we be collecting fees from families for services that are billable and non-Medicaid?
Answer: While not a requirement, this can be included as an income line in the proposal budget. Programs will not be allowed to deny services to any client due to inability to pay a service fee.

59. How will DCF know if the bidder has a positive working relationship with the designated MCIS provider in their service area (and what happens if in fact the bidder does not have a positive working relationship or has no relationship with MCIS at all)? Does the MCIS need to provide some kind of documentation or attestation?
Answer: There does need to be coordination with Mobile Crisis agencies and it is anticipated that Mobile Crisis will be a referral source and part of a comprehensive discharge plan. Your proposal should detail how your relationships will facilitate these collaborations.

60. Please affirm the UCC is a voluntary level of care (unless the UCC provider determines a PEC is necessary) and is an unlocked facility.
Answer: UCC is a voluntary level of care and is an unlocked facility.

61. What documentation is expected (and is it an attachment) to display a working relationship/partnership between the UCC bidder and the many entities noted in the RFP (hospitals, police, etc.)? Where is this to be included? Are these attachments?
Answer: The proposal should include a narrative describing the relationships. If formal MOUs have been executed prior proposal submission (not required), that should be noted in the narrative section of the proposal.

62. Please describe what the expected components are of a staff recruiting and retention plan for the UCC and/or Sub-acute stabilization program? Presumably this will take up a significant amount of space. Can this be an attachment (it is currently not noted as an attachment)?
Answer: Proposals should not include the comprehensive staff recruitment and retention plan. Proposals should provide a narrative description of efforts towards recruitment and retention of employees, agency incentives towards retention and successful recruitment and retention tactics that have been utilized by the applicant.

63. Can you please explain the billing structure for commercial insurance plans? With only 22% of CT families on Medicaid, negotiating commercial plans has been very challenging for behavioral health providers for decades. Many commercial plans have inferior/insufficient mental health coverage....knowing more about the plans around reimbursement would be helpful.
Answer: See question 14.

64. Within the RFP, you indicate that many screening tools are used to inform treatment paths and planning. While you identified the topics, you did not identify (other than the Columbia) specific screeners that you want utilized. Is choosing screeners solely up to the applicants' discretion or are there standard ones that you would like incorporated?
Answer: Other than the Columbia, it is expected that standardized screening tools will be utilized. For screening tools that are not well known, the applicant should describe the validity of these measures.

65. Are there specific measurement-based screenings/pathways that you wish us to use within the medical evaluation?
Answer: Medical evaluations should comply with current practice and compliant with licensing regulations.

66. In the RFP Purpose (#3), it states that if an applicant chooses Option A or Option B, 'partnership with the awarded provided (for the other option) will be required.' What will this look like?
Answer: At minimum, the partnership will require the coordination of referrals, intake, discharge and follow up.

67. Under contract management/data reporting, you cite that data will be collected using the applications developed for EBP Tracking, but then say that other data will be submitted into PIE. Are you saying that there will be two data systems that we must use in addition to our own medical record system?
Answer: The Evidenced Based Practice Tracker (EBPT) is a component of the Provider Information Exchange (PIE). It is one data system.

68. Can you define what you mean by 'medically cleared'?
Answer: The RFP uses the term 'Medically Stable', meaning not in immediate danger of a health-related incident resulting in physical harm.

69. What is your proposed 'start up' timeframe? You state you will complete review of the RFP and select recipients by October 1 and expect contract implementation to start on November 1.
Answer: It is the Department's intention to have contracts executed by November 1st. 2022. Proposals should discuss realistic implementation timeframes.

70. If we apply for both the UCC and SAS in same communities as one application, should we put together two separate budgets or combine both programs and show them segregated on the narrative?
Answer: One proposal should be submitted with 2 separate budgets.

71. What systems and procedures are in place to prepare emergency medical services organizations to transport children by ambulance to the UCC instead of the ED? What systems and procedures are in place to prepare sponsor hospitals to advise emergency medical services organizations on such transport to these alternate destinations?

Answer: While legislation has been passed to allow ambulance transport to the UCC, specific procedures for this component of the program are still under development.

72. Will new or existing licensing standards apply to the SACS program? If existing, which license will apply?

Answer: There are currently no applicable regulations for this level of service. For the time being, a Child Caring Facility license will be issued and additional requirements will be required through the contract.

73. Under the proposed regulations, could physical holds, mechanical restraints, and/or orally administered or injectable medications be used for crisis intervention?

Answer: The Department follows State Statute 814e: Physical Restraint, Medication and Seclusion of persons Receiving Care, Education or Supervision in an Institution or Facility.

74. The RFP notes that the use of subcontractors is not permitted. Does this prohibit applicants from including any contracted services in the application budget for things such as transportation, food, or laboratory services?

Answer: No, this does not prohibit contracted services for the items listed.

75. The staffing structure outlined in the RFP for both UCC and SACS does not account for weekend coverage. If justified, can an organization propose the same number of FTEs but change the allocation of roles?
Answer: Please refer to page 16 and 17 of the RFP. The staffing model utilized for budget development of this service was inclusive of weekend staffing. Applicants are free to propose a staffing model they believe to be sufficient to perform the requirements of the service, provided that a minimum of 3 staff be present on-site at all times.

76. We are supposed to submit photos of the proposed site if we have them. Are those meant to be captured as an attachment or incorporated into the text of the application?
Answer: Refer to Section IV (Proposal Outline) of the RFP.

77. Is DCF in communication with commercial insurers and/or with the CT Department of Insurance to determine whether commercial insurance will reimburse for this level of care? If yes, what has been the response from commercial insurers and/or DOI? If not, will DCF work with the Department of Insurance on this issue?
Answer: Yes, DCF is currently working with its sister state agencies regarding the reimbursement methodology for this service type.

78. What is the expectation for how these services will be billed and reimbursed? Appointment, inpatient, outpatient? Professional billing as well as facility charges?
Answer: Refer to question 14.

79. Can video visits be utilized to provide psychiatrist/APRN services for both the UCC and SAS level care?
Answer: No

80. Can video visits be used for all services (MD/APRN/RN/Social work at various times during the shift)?
Answer: No

81. Can you clarify the role of the On-Call RN in the SAS model and if that individual would be required to come into the facility or could provide services virtually?
Answer: It is expected that the on-call RN will respond to the facility as needed for urgent assessment of the youth, administration prn medication, etc.

82. Is DCF open to other staffing models for both the UCC and SAS care settings than those presented in the RFP? (given that the staffing models suggested may be insufficient to adequately support these children)
Answer: See question 75.

83. If the UCC and SAS are not co-located, can you clarify who would bear financial responsibility for transporting patients from the UCC site of care to the SAS Unit?
Answer: The UCC.

84. Who would be financially responsible for the cost of transportation for admitting a patient to a hospital?
Answer: This is dependent on the urgency of the need and whether the UCC transports the client to the hospital, or first responders and an ambulance are called to the program.

85. For the UCC, please clarify expectations around the 23-hour limit – what happens after this point?
Answer: Based on the clinical assessment of the UCC staff, and prior to reaching the maximum number of hours for the length of stay, a decision will need to be made whether a youth/young adult can be sent home, appropriately referred to the Sub Acute Center, be referred to a higher level of care, such as a hospital, as appropriate.

86. Please clarify how the crisis stabilization model is different from an inpatient unit.
Answer: Crisis stabilization is not an inpatient level of care. It is intended as an alternative for youth to have a temporary, short-term intervention to address their behavioral health needs without the need for a hospitalization or out of home placement.

87. Can patients be discharged from inpatient to a crisis stabilization unit while awaiting other services or placements, long term?
Answer: On page 14 of the RFP, it is noted that the Sub Acute Center may accept referrals from inpatient, as appropriate. It is expected that the referred must be assessed to no longer require a hospital level of care, and the length of stay in SAC is expected to be no longer than 14 days. This program is not intended for long term stays.